PLEASE SIGN AND THEN FAX OR MAIL TO ALBERTA BLUE CROSS AT THE ADDRESS LISTED BELOW.

ALBERTA BLUE CROSS®

FEBUXOSTAT
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME FIRST NAME INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS	PHONE:	FAX:
CITY , PROVINCE		
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Criteria for Coverage of FEBUXOSTAT

For patients with symptomatic gout who have documented hypersensitivity OR severe intolerance to allopurinol, AND intolerance or lack of response to sulfinpyrazone. Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

Please note: Coverage cannot be considered for lack of response to allopurinol.

☐ **NEW Please provide the following information for NEW requests (check ALL that apply):**

Diagnosis:

☐ Symptomatic gout ☐ Other (specify): _____

Previous medications utilized: Information is required for **EACH** of the following:

1) ☐ Allopurinol has been utilized:

☐ Documented hypersensitivity ☐ Severe intolerance ☐ Other (specify):_____

☐ Allopurinol has NOT been utilized. Please specify reason, if applicable:_____

_____

AND

2) ☐ Sulfinpyrazone has been utilized:

☐ Intolerance ☐ Lack of response ☐ Other(specify):_____

☐ Sulfinpyrazone has NOT been utilized. Please specify reason, if applicable:_____

_____

Additional information relating to request

☐ **RENEWAL:** This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period). **Please indicate response to therapy**:

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.